Managing a vascular surgery practice in the managed care environment

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California undoubtedly has become the nation's laboratory for the managed care experiment, which seeks to transform how health care is financed. The center of development of health maintenance organizations (HMOs) has been southern California, dating back to their introduction by Kaiser-Permanente in the 1930s. Although the list of criticisms of our health care system is long, its principal fault is financial cost. Spending 14% of the gross domestic product on health care will eventually cripple private enterprise and the public welfare.

Both business and government have embraced the HMO concept as the salvation of a health care system plagued by out-of-control expenditures. However, the medical journals and economists that praised this "new paradigm" for health financing reform as anodyne[1] now view it as anathema. Costs are once again on the rise, and patients' satisfaction with their health care insurance declines.[2,3] This apostasy comes as no surprise to the physicians and hospitals who toil under the micromanagement engendered by diagnosis-related groups (DRGs) and Resource-based Relative Value System—two highly touted reforms that failed to stem the tide of rising costs. The effects of HMOs, the government's latest incursion into vascular surgery practice, are the subject of this report.

THE NEW HEALTH CARE GAME

Dr. Jerome Kassirer, editor of the *New England Journal of Medicine* chose California's for-profit HMOs for an editorial diatribe that summarized their avaricious business objectives—expand your company, maximize the number of insured people ("lives"), charge less than your competitors, and make a nice profit.[4] In 1980, 85 of California's HMO plans were not for profit and more than 90% of HMO patients were enrolled in these plans. Kaiser-Permanente dominated this market and supported it with an extensive hospital and clinic network. As recently as 1994, 89.5% of these plans' premium dollars were devoted to direct patient care. By 1995, however, two thirds of the plans, the plans referred to by Kassirer, were for profit. In that year, nearly half of all patients in southern California were enrolled in HMOs, the vast majority of which were for profit. On average, something less than 75% of premium dollars were spent on direct patient care.[5] Meanwhile, Kaiser's market share was shrinking with resultant hospital closure and layoff of hospital personnel. Dollars were being diverted from patients, and the physicians and hospitals that provided them with care. Where are the dollars going? To administration and large salaries, to profits, to the often-overlooked accomplices of the HMOs—the for-profit Independent physician associations—and conspicuously to an advertising campaign that is encompassing all print and electronic media.

LOSS OF AUTONOMY

Many schemes have undermined the autonomy of the California physician. From 1978 to 1983, many insurance companies maintained mandatory second opinion programs but later abandoned them because they produced no demonstrable savings. Preadmission certification, introduced in 1987 under California Medical Review Initiative control, elaborated an arcane administrative network for precertifying ten major operations, including hysterectomy, prostatectomy, and cataract extraction. Vascular surgery was unique in that all arterial procedures required preadmission certification. This program is in the process of dying a quiet death. Of course, the most conspicuous loss of autonomy is the policy of having gatekeepers, who use guidelines of their own devising, decide which patients are to be seen by vascular surgeons. Gatekeepers also restrict postopera-

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Presented at the E. Stanley Crawford Critical Issues Forum of the Forty-fifth Scientific Meeting of The Society for Vascular Surgery and the Fifty-first Annual Meeting of the International Society for Vascular Surgery, Boston, Mass., June 2, 1997.
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J Vasc Surg 1998;28:358-60.

0741-5214/98/$5.00 + 0 24/9/91167

tive visits so that a cognitive program of patient follow-up care is impossible. Ongoing graft surveillance for infrainguinal revascularization, for example, is proscribed.

DEMORALIZATION

Demoralization is endemic to the physicians of southern California. It seems to be most virulent among surgical specialists but extends beyond physicians to include hospital employees in general and nurses. *Modern Health Care*[6] reported that among general hospital employees, the number of hospitals that rank morale as their most serious problem increased from 67% in 1994 to 86% in 1996. Improving morale is futile when one's coworkers are fired to achieve fiscal savings so that capitation rates can be met at the cost of quality patient care. It is estimated by the Advisory Board Company[7] that the new standards to be achieved by the year 2000 will produce a reduction in cost per adjusted discharge from $5572 to $3781. Full-time employees per adjusted occupied bed will be reduced from 5.1 to 3.8, and labor costs per net revenue will decrease from 50% to 35%. These reductions will be achieved through elimination of hospital employees, nurses in particular, further reducing quality of care.

Physicians are demoralized for reasons other than loss of income. They fear "economic credentialing," in which they risk loss of privileges if they spend more money than their peers do in the care of HMO patients. In our community, we see virtually no new private practice physicians; most new physicians work for either IPAs or HMOs. In southern California, because of a fourfold increase in early disability retirement applications, new claims are fiercely scrutinized. The policies that are now offered have higher premiums and more restrictive claims policies. Emigration of southern California physicians to the east is widely reported, many emigrants lamenting the erosion of standards for vascular surgical care. Decisions about inpatient care are shuttled along practice guidelines and clinical pathways devised by "hospitalists" with no understanding of vascular surgical care.

UTILIZATION, CAPITATION, AND PAYMENT

It is not as paradoxic as it seems that capitation rather than limiting utilization stimulates utilization. The southern California HMOs have established capitation agreements with most hospitals. IPAs, the patient care arm of HMOs, provide the hospitals with "hospitalists" and "intensivists," who not only provide care but also decrease resource utilization. These neospecialists are motivated by the HMOs to keep charges and costs down, although the HMOs, by capitating physicians, hospitals, and laboratories, have only second-order motivation to do so. Against this pattern of practice is the decline in hospital days for the Medicare population. In 1992, the national average for hospital days per 100,000 enrollees was 2835. In California, the average was 1200 days per 100,000, and for integrated staff-model systems (e.g., Kaiser-Permanente), it was approximately 900. Seen from another point of view, inpatient use rate per 100,000 adults was 110 in California, the state with the highest managed care penetration, and 160 to 170 in Mississippi and North Dakota, with the lowest HMO penetration. This decreased utilization and hospital expenditure by HMOs has affected non-HMO insurance plans. In 1994, the non-HMO payment for coronary artery bypass graft averaged $12,300 in southern California, $18,000 in northern California, and $25,000 to $27,000 in the other 46 continental United States.[7] Insurance carriers increasingly are scrutinizing these geographic differences.

REMUNERATION: THE CASE OF CAROTID ENDARTERECTOMY

From 1990 to 1997, most but not all vascular surgeons experienced a reduction in practice incomes ranging from 20% to 40%. This is in constant (real) dollars (not adjusted for inflation). Were the figures adjusted for inflation (nominal dollars), the decreases would be even more staggering. This same group of surgeons has experienced increases in workloads of 10% to 50%. Of the six surgical groups that I polled, all concluded, "We are working harder and getting paid less." Most vascular surgeons do HMO/IPA work for modified fee for service, capitation, or both. The changing remuneration pattern in our practice (based on actual estimate of benefits) is shown in Table I. In 1971, the amounts charged for carotid endarterectomy, aneurysm repair, and femorotibial bypass grafting were collected to within 95%. By 1986, remuneration, although failing to keep pace with inflation, increased on average by more than 100% with collections continuing to exceed 90% of billings. A decade later, the charges plummeted to levels approaching the 1971 collections.

The 1996 numbers reflect Medicare-fixed rates. In 1996, one renegade IPA established payment profiles that were so low we terminated our contract. For this IPA, the payment rates were, in fact, less than those of Medi-Cal (Medicaid) not only for surgical

TABLE I. Changing remuneration

Procedure	*1971*	*1986*	*1996*	*1996 Renegade IPA*
Carotid thrombo-endarterectomy	$1500	~$2600	$1507	$637.74
Abdominal aortic aneurysm repair	$1500	$3800	$2216	$740.75
Femorotibial bypass graft	$1400	~$3500	$2300	$583.13
Complex consultation	—	—	—	$72.50

intervention but also for complex consultation. A comparison of payment for carotid endarterectomy is shown in Table II. All payment sources—Medicare, HMO and preferred provider organization (PPO), and IPA—currently provide a 16% additional remuneration for assistants on their modified fee-for-service plan, whereas under capitation surgeons are responsible for providing their own assistants. Also of note is that many IPAs extract 20% withholding until the books are closed at the end of the year.

SUGGESTIONS

The growth of HMOs is ineluctable, and this will undoubtedly further diminish the traditional practice of vascular surgery. The following are suggestions for dealing with HMOs and IPAs in the future:

1. Upgrade your medical information system and keep it current. Accurate patient and payment data are imperative for dealing with insurance companies.
2. Confer frequently with your colleagues about practice patterns and payment.
3. Avoid capitation.
4. Include in your negotiations (capitation or fee for service) payment of fees, inclusion of assistants' fee, elimination of no withholds, and specification of all deductions up front.
5. Make sure you are permitted to provide follow-up care to your patients with as little interference as possible.
6. Establish a "paid-for" graft surveillance program if you can.

TABLE II. Carotid endarterectomy, 1997

Organization	*Allowed*	*Payment*	*Secondary*	*Assistant*
Medicare	$1507	$1205	$302	Yes
HMO/PPO	$1485	$1485	—	Yes
IPA	$1205*	$964*	—	Yes

*Withhold 20% (~$231).

7. Specify a payment timetable and stick to it.
8. Confirm frequency of review. Perform an accurate, up-to-date census of enrollees and compare the utilization data from your medical information system with that of the IPAs.
9. Although most of your income will be from Medicare "lives," do not underestimate the payment, particularly capitation, for commercial lives.
10. If possible, procure an exclusive contract.
11. Even if you have an exclusive contract, determine whether a third party can contravene your recommendations.

HMO administrator-entrepreneurs have different motivation and incentives than do practicing vascular surgeons. For now they hold most of the cards. Dealings with them will succeed only with careful planning, negotiation, and data management.

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Submitted Sep 23, 1997; accepted Jan 30, 1998.